Substance Abuse Intensive Outpatient Program Review Form

INITIAL: ☐ **CONCURRENT:** ☐

All information requested on this form must be complete; missing data may result in delay of authorization. There is no authorization guarantee for retrospective authorization requests.

Today's Date: _____ **Client's Name:** _____
Date of Birth: _____ **SS #/ID # of card holder:** _____
Facility/Program Name: _____
Facility Tax ID #: _____ **State:** ____ **Zip Code:** _____ **Fax #:** _____
Submitting Staff Name/Credentials: _____ **Phone #:** _____
Attending MD Name: _____ **Phone #:** _____

Continued Authorization Request:

Level of Care (Please Check One**):**
IOP: ☐ **Phase 1-4 (If contract delineates):** ☐ **Low Intensity OP:** ☐ **After-Care:** ☐

 # Sessions attended to date: _____ **Additional sessions requested:** _____
Requested start date of new auth: _____ **# Sessions per week:** _____ **# Hours per session:** _____

Diagnosis with DSM IV codes: (Include any changes**)**

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: Current_____ **Baseline** _____
MH assessment completed: ____ **Outline plan to address any MH issues:** _____

_____

Client's current medication (Include all changes**):**

1. _____ **2.** _____ **3.** _____

The client's current Stage of Engagement in substance abuse treatment (Place "X" on Correct Line):

Pre-Contemplation:	_____	**(Client is not yet considering change)**
Contemplation:	_____	**(Client is ambivalently weighing the pros and cons of change)**
Determination/Preparation:	_____	**(Client makes a beginning commitment to the change process)**
Action:	_____	**(Client is taking specific steps toward accomplishing change)**
Maintenance:	_____	**(Client is maintaining the changes made)**
Relapse:	_____	**(Client temporarily returns to pre-change behaviors)**

Client's current status ("Y" or "N"):

____ **Is the client attending a 12 step program?**
____ **Is the client connected with a 12 step "sponsor"?**
____ **Have external motivators (work, church, legal, family, friends) been involved in treatment?**
If "No", when are you planning for them to be? _____
____ **Have relapse triggers been identified?**
____ **Is the client actively working on a relapse prevention plan?**
____ **Are outreach attempts made to assess and engage the client when there is a "no show"?**
____ **Is the program utilizing urine drug screens?**

If the answer to any of the above questions is "No", please explain: _____

CIGNA Behavioral Health

Date of client's last use: _____

The client currently finds support from:
Work _____ **Friends** _____ **Community** _____ **Home** ___ **Church** ___ **Legal** _____ **None** _____

Date of last family/support session: _____ **Outcome:** _____

_____

If no family/support session, when is one planned? _____

Describe the current functional impairment (describe what responsibilities or activities are currently impaired and what role the current symptoms have on the impairment):

_____

_____

_____

How does the client verbalize his/her goals of treatment?

1. _____
2. _____
3. _____

Client's progress toward his/her treatment goals (If no progress, identify barriers):

1. _____
2. _____
3. _____

What are the specific behavioral changes that must occur in order for the client to be appropriate for discharge to routine outpatient treatment? (discharge criteria):

_____

_____

_____

Planned discharge date: _____ **If discharge date has changed, please explain:** _____

_____

Client aware of planned discharge date: _____ **Client involved in discharge planning:** _____

Aftercare Plan (Provider Name, Number, Credentials, Appointment Date, and Time**):**

_____

_____

_____

_____

Will you need assistance with aftercare planning? _____

Submission of this form and any subsequent authorization of visits by CIGNA Behavioral Health do not guarantee claims payment. Payment for services rendered is contingent upon the participant's current health benefit eligibility status, co payments, and available mental health/substance abuse benefits. Please note that benefit and/or coverage changes can occur on an account's anniversary date, which is often at the end of the calendar year. If you have any questions regarding your participant's eligibility, please contact CIGNA Behavioral Health at the number on the back of the participant's identification card.

Please fax this form to CIGNA Behavioral Health: (860) 687-7329

REVISED 2/09

CIGNA Behavioral Health

IOP Discharge Summary

Please complete only after client has concluded IOP

CLIENT'S NAME: _____

SS #/ID # OF CARD-HOLDER: _____

CLIENT'S DOB: _____ LAST AUTHORIZATION # RECEIVED: _____

UTILIZATION REVIEW PERSON/COUNSELOR/CARE MANAGER NAME & PHONE #:
_____

FACILITY'S NAME/CIGNA BEHAVIORAL HEALTH PROVIDER#:
_____

WAS THIS: ☐ MH IOP ☐ CD IOP

FIVE AXIS DX AT DISCHARGE:

AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V _____

OF IOP SESSIONS ATTENDED: _____ DATE OF DISCHARGE: _____

THE REASON FOR THE DISCHARGE IS:
_____ SUCCESSFULLY COMPLETED TREATMENT
_____ BENEFITS EXHAUSTED
_____ DROPPED OUT OR NO SHOWED MORE THAN ONCE
_____ TRANSITIONING TO ALTERNATIVE LEVEL OF CARE (_____)

MEDS AT D/C: _____

PROGNOSIS: __ EXCELLENT __ GOOD __ FAIR __ POOR

THE FOLLOW UP APPOINTMENTS ARE AS FOLLOWS:
__ MD APPT WITH DR._____ ON _____ FOR MEDICATION MGT.

__ THERAPIST APPT WITH _____ _____ ON _____ FOR THERAPY

ANY OTHER RECOMMENDATIONS FOR FOLLOW-UP CARE:
_____

PLEASE FAX THIS FORM TO CIGNA BEHAVIORAL HEALTH: (860) 687-7329